



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR JOSEPH ALLEN
7401 S MAIN
HOUSTON TX 77030

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-2542-01

MFDR Date Received

APRIL 4, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "carrier paid this code as anon fac and should be paid as facility setting."

Amount in Dispute: \$37.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to additional reimbursement for CPT code G0289 based on the difference between the facility and non-facility fee amounts. As documented by the attached CMS fee schedule excerpt, the facility and non-facility reimbursements are the same."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2011	CPT Code G0289	\$37.17	\$37.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- W1-Workers compensation state fee schedule adjustment.
- Z013-This bill has been processed correctly per the state fee schedule.
- MC03-W1/# subject to multiple procedure discounts and is paid at 100 percent of the fee schedule amount per the Texas physician fee schedule, Medicare guidelines.

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2011 DWC conversion factor for this service is 68.47.

The Medicare Conversion Factor is 33.9764

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77598, which is located in Harris County.

The Medicare participating amount for code G0289 in Harris County is \$90.68.

This code is not subject to multiple procedure rule discounting.

Using the above formula, the MAR is \$182.74.

The respondent paid \$145.56. The difference between the MAR and amount paid is \$37.18. The requestor is seeking \$37.17; this amount is recommended in additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$37.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$37.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

08/15/2013

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.